THE UNIVERSITY
OF BIRMINGHAM

Health Services Management Centre
School of Public Policy

Managing prescribing in PCGs

Darrin Baines, Rosa Legood and Judith Smith

Introduction

To help support Primary Care Groups (PCGs) in the management of the prescribing element of their unified budgets, HSMC and the Health Economics Facility within HSMC are running a series of seminars on prescribing and PCGs. This briefing note summarises the findings of the second seminar in the series held on 18th May 1999. Details of further seminars in the series and copies of the briefing notes from later seminars may be obtained by completing the coupon printed on page three.

Speakers		
	Judith Smith	Fellow, HSMC, University of Birmingham
	Darrin Baines	Senior Lecturer, Health Economics Facility, HSMC
	Azeem Majeed	Medical Epidemiologist, Offices for National Statistics
	Keith Beard	Consultant Physician, Victoria Infirmary NHS Trust, Glasgow
	Robert Queensborough	Medical Director, Wigan & Bolton Health Authority
	Tony Avery	Senior Lecturer & Head of General Practice Division, University of Nottingham
	Kieran Walshe	Senior Fellow, HSMC

Introduction and agenda setting

Judith Smith

Judith opened the seminar by presenting some of the early lessons from the Primary Care Group (PCG) evaluation work being carried out by HSMC. She noted that a *range* of techniques were being employed for the management of PCG prescribing budgets. These included PCGs allocating practice level budgets, the use of prescribing advice, visiting local practices and the use of feedback/audit of Prescribing Analysis and CosT (PACT) data. The majority of practices were sharing PACT data between practices, holding regular prescribing meetings, issuing local prescribing guidelines, using local performance league tables, and seeking to manage the entry of high cost new drugs. Almost half of the PCGs had a local formulary in place.

PCGs reported having experienced a number of problems when seeking to manage the prescribing budgets. These issues included the prescribing policies of hospitals, the targeting of practices by pharmaceutical industry representatives, and patient demand for high cost products. Some PCGs also cited general practitioners having inadequate knowledge or training about prescribing issues, or general practitioners failing to respond to PACT reports as being issues of concern to their work on prescribing.

Judith noted that a variety of organisational issues were raised for PCGs by this research, which included:

(i) encouraging PCGs to see managing prescribing as primarily about *quality* rather than costs

(ii) encouraging the sharing of information between practitioners and practices

(iii) developing a culture of peer review which feels safe

(iv) engaging with community pharmacists in the PCG

(v) developing a working relationship with local trusts.

Judith also emphasised the need for a strategic framework to guide prescribing activities, which should be amended and agreed upon by PCGs and their boards. In conclusion, Judith identified four likely challenges to be faced by PCGs in relation to the management of prescribing:

(i) dealing with variations between practices

(ii) seeing prescribing as part of the wider organisational development of the PCG

(iii) operating within clinical governance principles

(iv) developing a strategic approach for the management of prescribing.

A strategic framework for prescribing management

Darrin Baines

Darrin discussed issues related to the implementation of a strategic framework for managing prescribing in PCGs. For PCGs to promote rational and affordable prescribing, he argued that planning, strategy and governance are required. Hence, PCGs needed to agree local norms and appropriate governance strategies. Prescribing was influenced by the rationality of prescribers and the costs of particular medicines. He emphasised that rational prescribing means maximising benefits per pound spent, not minimising expenditure on drugs.

According to Parish's definition, Darrin explained that, 'rational prescribing' involves evaluation of whether prescribing is 'safe, effective, appropriate and economic' at a patient level. In this context, economic did not mean expenditure, but costs and benefits. On the other hand, 'affordability' was whether a particular drug might be afforded within a given budget. However, the NHS could not always afford to prescribe cost-effective drugs. That was why budget limits often conflict with attempts to be rational or economic.

Prescribers were not fully rational because they had: (i) insufficient processing power, and (ii) insufficient information. Therefore, to overcome 'bounded rationality' PCGs would need measures to improve the processing of evidence by prescribers and the information available about best practice. Individuals might choose 'focal points', or jump on 'band-wagons', that is (concentrate on particular sources of information or copying the behaviour of other prescribers). These might be used to both explain prescribing behaviour and influence prescribing behaviour. Within a locality, PCGs should use 'focal points' and 'band-wagons' to promote agreed norms for local prescribing.

Darrin suggested 'conformative prescribing' as an alternative to 'rational prescribing'. In this context, conformative did not necessarily mean conforming. Conformative is just a 'reason for following or *not* following a rule'. For example, following a local PCG prescribing guideline or not.

According to Darrin, the way forward for PCG prescribing is:

(i) government initiatives that will set common standards across all PCGs

(ii) PCGs setting local standards, with local norms and conventions, and

(iii) PCGs using systems that promote conformative prescribing.

In conclusion, Darrin argued that:

(i) rational prescribing must be traded off with affordable prescribing

(ii) PCGs cannot truly judge the rationality of *all* prescribing, as they do not have the necessary patient data

(iii) PCGs should promote conformative prescribing that leads to beneficial change.

Setting PCG and practice level prescribing budgets

Azeem Majeed

Azeem explained that general practitioner prescribing costs were now more than 11% of NHS spending. They were increasing more rapidly than the general inflation rate and the increase in NHS spending. There were wide variations in the costs and volumes of prescribing and the implications of these factors were that there is: pressure to control prescribing costs, improve the quality and appropriateness of prescribing and also to develop 'fairer' methods of allocating prescribing budgets to health authorities, PCGs and individual practices. Budgets had been traditionally based on historical spending, but a new formula was introduced by the NHS Executive in 1996. This included weightings for size of population, age, sex, and permanent sickness. The NHS Executive advised health authorities to give a larger increase to practices with below average costs and some authorities were trying to develop more sophisticated methods of setting budgets.

Only 30-40% of the variation in costs between practices could be explained and the cause of remaining variation is unexplained. Azeem suggested that there were a number of reasons why there may be unexplained variation in prescribing costs; which include;

(i) idiosyncratic or inefficient prescribing

(ii) differences in clinical characteristics of patients registered with practices

(iii) some practices being better at identifying and treating patients with chronic disorders.

Azeem stated that high cost prescribing was not necessarily bad, for it might reflect high quality.

PCGs would take devolved responsibility for a single unified budget covering most aspects of care so that they called get the best fit between resources and need. It would provide local family doctors and community nurses with maximum freedom to use the resources available to the benefit of patients, with incentives at both PCG and general practice level. In the past, health authority budgets had been separated between general medicine, hospital and pharmaceutical services. In the future, PCGs will receive a global budget for all those services. The advantage of this new system was that PCGs could move funds between different budgets.

Azeem explained that the implications of unified budgets would be that any overspends on prescribing costs will affect other health services. PCGs should consider the introduction of a prescribing strategy, liaison with local hospitals and changes in practice circumstances, (such as high cost patients and changes in list size). The national formula for budget-setting has components for hospital services, prescribing and general practice infrastructure. The key issues in the allocation to PCGs would be counting the population, measuring need, adjusting for unavoidable costs and the pace of change. For most PCGs, there will be a gap between current and target allocations.

The setting of drug budgets could be improved by removing costs of expensive drugs, weighting for age and sex, considering factors that could increase costs, discussing the management of chronic diseases, identifying areas where there were potential cost savings and providing feedback and reinforce good practice.

In conclusion, Azeem suggested that clinical practice could be changed through:

(i) feedback of data on prescribing

(ii) educational initiatives

(iii) clinical guidelines

(iv) financial inducements

(v) closer liaison with hospitals.

Effective prescribing - can the needs of patients, doctors, managers and governments be reconciled?

Dr Keith Beard

Keith Beard commenced by outlining medicines management activities in Glasgow. The Area Drug Therapeutics Committee (ADTC) for Glasgow advises the Greater Glasgow Health Board on all therapeutics related issues. Health Boards sit directly beneath the national level as there are no regions in Scotland. All new drugs, formulations and indications are assessed routinely on a two-monthly basis. The Area Drug Information Service prepares an information 'package,' which examines pharmacology, evidence of effectiveness, etc. Local experts are used to examine the likely role of the new drugs. A subcommittee makes recommendations on approval, restricted approval and non-approval for formulary status, the ADTC takes final decisions. There is an appeals system for new drugs initially turned down for formulary inclusion. Keith set out the strengths of this approach as being the links between trust drug and therapeutics committees (DTCs) and area DTCs; pooled expertise; general practitioner involvement at all stages and the use of a joint formulary. Weaknesses included: the image as a cost cutting arm of the board; lack of good data on hospital drug use; imprecise evaluation of new drugs; and the lack of economic input.

The Scottish Health Technology Assessment Centre (SHTAC) discussion paper was mentioned by Keith, SHTAC being the equivalent of the National Institute of Clinical Excellence in England and Wales. The role of SHTAC in the assessment of new or expensive drugs was not yet certain, but was likely to include horizon scanning for new drugs and indications, commissioning evidence-based reviews and economic evaluations.

Keith explained that the Glasgow formulary was published in a slim pocket sized book with six cumulative updates published annually. The formulary applied to hospitals and general practitioner. Hospitals could use subsets as may Local Health Care Co-operatives and it was also available on a website. The list was published in British National Formulary categories and includes some brief prescribing notes. The Glasgow prescribing newsletter, *PostScript*, includes summaries of administrative procedures, selected detailed reviews of new drug decisions plus short articles and reviews on matters of drug safety, practical prescribing and cost effectiveness. It was widely distributed to the entire prescribing community of Glasgow and was also available at **www.show.scot.nhs.uk/gghb/adtc** on the internet. The effectiveness (outcomes) programme considered whether newly licensed drugs were efficacious and safe not just in clinical trials, but in the real world of clinical practice.

According to Keith, the broader issues include:

(i) can specialists take a society-wide view?

(ii) what about the big picture of the public health?

(iii) what about social deprivation?

(iv) what about low cost-effectiveness interventions?

Keith asked whether doctors should accept health gains shown in randomised control trials and abandon the effectiveness agenda, ignoring pressures and demanding a huge increases in funding. He also posed the alternative he input, whereby they would accept that prioritisation and rationing meant a two-tier NHS with expensive services funded by co-payment or insurance. The third way was perhaps to engage government, NHS management, clinicians and patients in the debate. Keith also outlined a new model for bridging the gap between new therapies and necessary care with the hospital prescribing adviser, the medical prescribing adviser, the drug information service and an economist at the hub of activity. Keith summarised by setting out the way ahead, including;

(i) involving efficient assessment of new drugs

(ii) it a greatly expanded effectiveness (outcomes) programme with a single set of rules across the prescribing community

(iii) more information and education for both general practitioners and hospital prescribers.

Generating prescribing savings: findings of a Department of Health sponsored study

Dr Tony Avery

Tony explained that in 1994, the Audit Commission suggested how general practitioners might save up to £425 million on their prescribing costs. Following this, the NHS prescribing research initiative asked for bids on how do general practices make savings on their prescribing costs? Tony had been asked to do a range of studies related to study around the question. Project involved a multidisciplinary team from the University of Nottingham and Doncaster Health Authority and was comprised of the four studies set out below.

Study 1:
How do General Practitioners control (or increase) their prescribing costs?

Tony explained that the following three groups of practices were selected from the Trent Region based on their change in costs per prescribing unit between 1994-5 and 1995-6. The study found that practices controlled costs through decreasing prescribing volumes and costs per item, and increasing generic prescribing rates. Most importantly, they increased generic prescribing where it made a substantial difference to costs. In general therapeutic areas, costs were controlled, for example, by decreasing costs/1000 patients for: (i) infections, (ii) musculoskeletal drugs, (iii) combination products, and (iv) modified/sustained release drugs, and the control of costs for 'new and expensive' drugs.

With respect to quality indicators, Tony reported that the practices making relative savings did the following: (i) increased prescribing of lipid lowering agents, inhaled corrticosteroids and Hormone Replacement Therapy (in line with other groups); (ii) reduced prescribing in areas where it has been suggested that GPs may over prescribe, (e.g. antibiotics, hypnotics, NSAIDs and drugs of limited clinical value); (iii) reduced prescribing areas where it has been suggested that this can be done without detriment to patients, (e.g. most generics).

Tony added that the group of practices with large increases in costs had increases in prescribing volume and cost per item. There were large increases in costs for new and expensive drugs, modified/sustained release drugs, and combination products. Also, despite a generic rate increase, no generic savings had been achieved.

Study 2:
Survey of GP's in high and low cost practices in 1998 as to their attitude to cost control.

Tony explained that most GP's are sympathetic to the idea of controlling costs where this can be done without detriment to patient care. For example, drugs of limited clinical value, generic prescribing, and certain therapeutic substitutions were usually acceptable areas for controlled costs. He accepted that the study revealed a greater proportion of GP's in high-cost practices had expressed a preference for certain 'premium price preparations'.

Study 3:
Can pharmacists help GP's to control costs?

This study involved an evaluation of the Doncaster Prescriber Support Project, in which eight practices received dedicated input from pharmacists. Pharmacists had the skills to analyse prescribing patterns and the organisation of prescribing. They were able to suggest or actually make changes, and following agreement with GPs. Tony reported that practices with pharmacists saved twice the costs compared with eight control practices. He assessed that PCGs were likely to benefit from the support of pharmacists, but need to know what work best. The key issues in effective pharmacist support were: (i) having reliable information on which to base priorities for action. (ii) Agreeing on the role of the pharmacist. (iii) Breaking down barriers (iv) allowing the pharmacist to make changes. (v) providing intensive input to a small number of practices rather than advice to all practices in a PCG.

Study 4:
Patients' views on cost-control

According to Tony explained that the factors which predicted patient satisfaction with changes in medication included whether they were told of the planned change by the practice pharmacist, their GP, or by letter. And the patients feeling that they had a choice and that they had been told why the change was being proposed, were also key sectors. Tony noted that the key messages for PCGs from this programme if research were that the successful methods for controlling costs were:

(i) controlling the uptake of new and expensive drugs

(ii) switching from brand named to generic preparations, particularly where this would make appreciable savings

(iii) controlling costs for modified release and combination products

(iv) reducing prescribing volume where appropriate.

In conclusion, Tony stated that when PCGs were encouraging practices to control costs they should note that:

(i) most GP's are sympathetic to the idea of cost-control

(ii) the most important area of dispute is around premium price preparations

(iii) key problem for GP's is lack of time

(iv) better information on cost-effectiveness may help

(v) incentives often help.

Modifying prescribing behaviour: who should be targeted and how?

Dr Robert Queensborough

Robert began by explaining what an 'outlier' really meant. He stated that an 'outlier' could be defined as:

(i) that which lies, or is, away from the main body

(ii) an extreme deviation from the mean.

He emphasised the need to be careful about extremes because For most outliers there were multiple explanations. Rather than focusing purely on outliers, Robert proposed a different strategy aimed at diffusing change as quickly as possible. Robert used the work of Everett Rogers, which splits people into six different categories. This work argued that

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contact: ***Darrin Baines*** tel. 0121 414 7705. Email: bainesdl@hsmc.bham.ac.uk

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the first to take up new ideas are the **Innovators**, who are venturesome to point of obsession. They need resources to buffer possible losses. They have the ability to understand and apply complex technical knowledge to cope with high degree of uncertainty to import new ideas into the system.

The next 13.5% are the **early adopters**. They are interested in new idea implementation and are well respected by peers. By adopting new ideas, this group decreases uncertainty and can convey subjective evaluation to peers through interpersonal networks. By stimulating communication between this group and the next, new ideas can be implemented quicker.

The next 34% are the **early majority**. They adopt new ideas just before the average member and interact frequently with peers, although they seldom hold positions of opinion leadership. They may deliberate for some time before adopting new ideas. They follow with deliberate willingness. They form a link between very early and relatively late adapters of change.

The **late majority** 34% need peer pressure to motivate and adopt innovation. They are sceptical and cautious and they do not adopt until most other have done so.

The remaining 16% are the **laggards**. They possess almost no opinion leadership and are the most change in outlook. Their decisions are often made in terms of what has been done previously and they must be certain that a new idea will not fail before they can adopt it.

Robert explained that the diffusion of innovation was dependent on relative advantage, compatibility, complexity, trialability and observability. Relative advantage may be measured in economic terms but was more likely to be based on social prestige, convenience and satisfaction important. The greater the perceived relative advantage of an innovation, the more rapid its would be rate of adoption. Compatibility was the degree to which the innovation was perceived as being consistent with existing values, past experiences and the needs of potential adopters. The less complexity, the simpler it was and the quicker an innovation would be adopted. Therefore, the simpler the idea the better. Robert explained with respect to trialability and observability, new ideas that could be tried out beforehand would generally be adopted. For example, if GP's could look at someone else's computer system working they may be more likely to adopt it.

Support was another key issue cited by Robert. PCG prescribing leads needed to delegate a lot of prescribing support to pharmacists, community/trust pharmacists, health authority advisers, and practice teams, (including doctors, nurses, pharmacists, receptionists with everyone supporting). According to Robert, the modifying of prescribing behaviour could be achieved through;

(i) **focusing on introducing the required innovations**

(ii) **concentrating activities on getting the use of the innovation to the point of critical mass**

(iii) **employing multiple strategies**

(iv) **using interpersonal networks**

(v) **keep inspection and discipline in their place, not allowing them to dominate.**

Prescribing and clinical governance in primary care

Kieran Walshe

According to Kieran, clinical governance had not been received with enthusiasm by all clinicians. Some so it as:

(i) **new name for old ideas - "we've been doing this for years"**

(ii) **managerialism and bureaucracy run riot**

(iii) **being bad for professionalism and clinical autonomy - and therefore bad for patients too**

(iv) **ideal but impractical - costs, time, and so on.**

Kieran argued that what was different about clinical governance was:

(i) **"The shift to corporate accountability"**

(ii) **The degree of managerial involvement**

(iii) **organisational focus, quality moving from the fringe to mainstream. Requirement to demonstrate an effective process having been put in place.**

Kieran assessed the future of clinical governance in primary care in 2003. He envisaged primary care organisations as having:

i) **Drugs and therapeutics, investigation and referral, condition management**

(ii) **Clinical performance review committees dealing with complaints, adverse events, issues, practice visits and routine data**

(iii) **A director of pharmacy services**

(iv) **Integrated group prescribing and dispensing**

(v) **Volume purchasing by a PCG consortium**

(vi) **Common, computerised, patient specific guidelines.**

Conclusions

Summing up the findings of the day, Judith Smith identified five key issues:

(i) **Prescribing management in PCGs would involve a quality/cost balance between quality and costs**

(ii) **Modifying performance require both incentives and support**

(iii) **There were many new ideas for pharmacist, Drug and Therapeutic Committee plus Primary care Trust**

(iv) **New alliances were emerging both within the NHS and with external pharmaceutical players**

(v) **Primary care management needed multiple strategies to achieve change, particularly in the prescribing.**

Please return to:
Darrin Baines,
Health Services Management Centre,
University of Birmingham,
Park House,
40 Edgbaston Park Road,
Birmingham B15 2RT.

Telephone: 0121 414 7050
Fax: 0121 414 7051